

**D. Cochran**  
**MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

**63-043553**

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1672

STATE FILE NUMBER

VS 300  
Rev. 4/59

10397

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94200

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <b>GREENE</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. <b>MISSOURI</b> b. COUNTY <b>HOWELL</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>SPRINGFIELD</b>		c. CITY OR TOWN <b>WEST PLAINS</b>	
Length of stay in 1b <b>1 DAY</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>BAPTIST HOSP.</b>		d. STREET ADDRESS (If outside, give location) <b>SANDERS CORONERS</b>	
Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First Middle Last <b>ROY ELWOOD MARSHALL</b>			4. DATE OF DEATH Month Day Year <b>NOV. 27 1963</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>7/8/05</b>	9. AGE (last birthday) <b>58</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MACHINIST</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>MISSOURI</b>	
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		13a. FATHER'S NAME <b>LEWIS MARSHALL</b>		13b. MOTHER'S MAIDEN NAME <b>ETHEL BEACH</b>	
14. NAME OF HUSBAND OR WIFE <b>LOLA MARSHALL</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>LOLA MARSHALL, WEST PLAINS, MO.</b>		Address			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>AS/12c acute myocardial infarction</b>		INTERVAL BETWEEN ONSET AND DEATH <b>19 days</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
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20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year			
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE
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21. I attended the deceased from <b>11/26/63</b> to <b>11/27/63</b> and last saw her alive on <b>11/27/63</b> Death occurred at <b>11:45 P.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE <b>D. Cochran MD</b> (Degree or title)	22b. ADDRESS <b>Springfield Mo.</b>	22c. DATE SIGNED <b>11/29/63</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>12/1/63</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MT. CALM CEMETERY</b>	23d. LOCATION (City, town, or county) <b>FULTON COUNTY, ARK.</b>
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24. FUNERAL DIRECTOR <b>H.H. LOHMEYER FUNERAL HOME</b> ADDRESS <b>SPRINGFIELD, MO.</b>	25. DATE RECD. BY LOCAL REG. <b>12-2-63</b>	26. REGISTRAR'S SIGNATURE <b>Bernice Medley</b>
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USE BLACK INK  
OR  
TYPEWRITER RIBBON

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*Levin T. Shadley*

Licensed Embalmer No. \_\_\_\_\_

*4815*

P. O. Address \_\_\_\_\_

*Springfield, Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.

11-29-63